Health History Form

Office Use: ☐ Profile ☐ Health Hx ☐ SOC ☐ ML ☐ SOAP

Treatment Type: ☐MR _____ ☐MMC _____ ☐T _____ ☐R _____ ☐P _____ ☐C ______

Today's Date:____________________________ Referral from:______________________________________

Name:____

Birthdate:_________________________________ Occupation:______________________________________

Phone#: Home_______________________ Work:___________________ Mobile:_________________________

Enable SMS Text Messages for appointment confirmation and reminders: YES NO

Enable Email for appointment confirmation and reminders: YES NO

Email address:____

Address:___________________________________City:_____________________ Postal Code:_____________

Emergency Contact & Phone#:____

Please list any medication you are presently taking & why:____

____

____

Previous Massage Therapist? YES NO If yes, when was your last treatment?________________________

Primary Care Physician:____

Indicate other forms of treatments you are presently receiving (Chiropractor, Physio, Etc.):_______________

____

Please list and include dates:

- Injuries:____

  ____
- Accidents:____

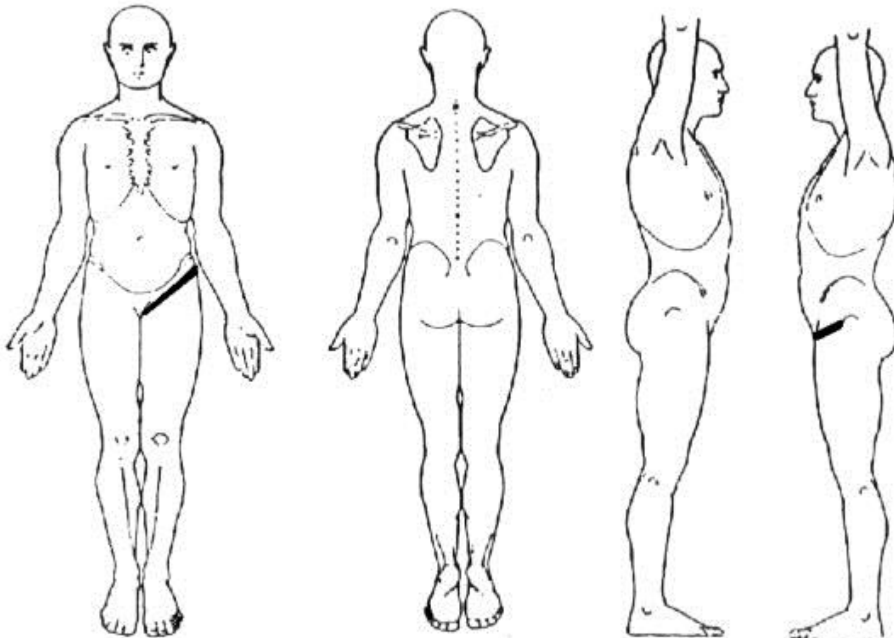
  ____
- Surgeries:____

  ____

What is your general health status?____

Reason for visit or primary complaint?____

Please indicate areas of pain:



Please √ if recently applicable and (Circle) for family history

Cardiovascular:

- ☐ Blood Pressure H or L
- ☐ Chronic Congestive Heart Failure
- ☐ Varicose Veins
- ☐ Heart Attack
- ☐ Stroke
- ☐ Heart Disease
- ☐ Arteritis
- ☐ Phlebitis
- ☐ Arthrosclerosis
- ☐ Pacemaker
- ☐ Other device

General:

- ☐ Allergies:_____________
- ☐ Hives
- ☐ Headaches (tension)
- ☐ Migraines
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Anemia
- ☐ Diabetes Type 1 or 2
- ☐ Constipation
- ☐ IBS
- ☐ Irritable Skin Condition
- ☐ Bruise easily (medical reason)

Muscle/Joint

- ☐ Arthritis:
  - Rheumatoid
  - Osteoarthritis
- ☐ Bursitis
- ☐ Joint Instability
- ☐ Ankylosing Spondylitis
- ☐ Scoliosis
- ☐ Sciatica
- ☐ Degenerative Disc (DDD)

Other:

- ☐ Osteoporosis
- ☐ Colitis
- ☐ Crohn's
- ☐ Hemophilia
- ☐ Epilepsy
- ☐ Multiple sclerosis
- ☐ Parkinson's
- ☐ Cancer:______________
- ☐ Vision/Hearing loss
- ☐ Sensation loss
- ☐ Pins/plates
- ☐ Prosthesis
- ☐ Fibromyalgia

Respiratory:

- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Smoker

Infectious Disease:

- ☐ Tuberculosis
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Plantar warts
- ☐ Infectious skin disorder

Women:

- ☐ Previous Pregnancies (dates)_______________ ______________________
- ☐ Pregnant: Due Date _________________
- ☐ Painful menstruation
- ☐ Pre/Menopausal

Other Health Conditions:

____

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Remissio Massage

I hereby consent to my Therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my Therapist.

I acknowledge that the Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Therapist and disclosed to the Therapist all of those medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my Therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party billing companies.

I will honor the **24 hour** notice required for any changes made to or cancellation of my appointments and will be responsible for full fees charged due for the cancelled session time as well as a late or missed appointment and understand that this charge is not billable to my insurance company for a late or missed appointment.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my Therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Patient Name:_________________ Signature of Patient or Guardian:_______________

Witness:_____________________ Date Signed:__________________________